SALISBURY UNIVERSITY
STATE OF MARYLAND

REQUEST FOR FAMILY AND MEDICAL LEAVE

EMPLOYEE INFORMATION (To be completed by the employee – Please print)	
1. Name:	**2. Employee ID:**
3. Job Title:	**4. Department:**
5. Reason for requesting leave: **a.** ☐ Birth of a child or placement of a child with you for adoption or foster care; **b.** ☐ Your own serious health condition; **c.** ☐ To care for your child, spouse, or parent with a serious health condition; **d.** ☐ Qualifying exigency arising out of the fact that your spouse; son or daughter; or parent is on covered active duty or call to covered active duty in support of a contingency operation; **e.** ☐ You are the spouse, son or daughter; parent, or next of kin of a covered service member with a serious injury or illness.	
6. Caring for a Family Member/Next of Kin: **a.** If 5c, 5d, or 5e is checked, please indicate: ☐ Child ☐ Parent ☐ Spouse ☐ Next of Kin **b.** Name of Family Member/Next of Kin: _____	
7. Effective Date of Leave Request:	**8. Date of anticipated return to work:**
9. Are you requesting leave on an intermittent or reduced work schedule? ☐ Yes* ☐ No * If yes, on a separate sheet give a schedule of when you anticipate you will be unavailable for work, if known.	

EMPLOYEE AGREEMENT

I hereby agree that while I am on leave, I will continue to pay my share of health insurance and other benefit premiums, unless I elect to discontinue such coverage. I also agree that if I fail to return to work at the end of the leave period, I will reimburse my agency for the cost of health benefits provided during my leave, unless I fail to return to work because of the continuation, recurrence, or onset of a serious health condition or because of other circumstances beyond my control. If I am unable to return to work because of a serious health condition, I will provide medical certification from the appropriate health care provider stating that I am unable to perform the functions of my position on the date that my leave expired, or that I am needed to care for a covered relative because he/she has a serious health condition on the date that my leave expired. I understand that I will use all available paid leave and that while on FMLA leave, I will contact the Human Resources Department after I have been on leave for 30 calendar days and at the end of each 30-day period afterwards.

Employee Signature:_____**Date:** _____